SENATE GENERAL WELFARE COMMITTEE AMENDMENT 1

FILED
Date _____
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Clerk _____
Comm. Amdt. _____
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Amendment No. 1 to SB0559

Crowe
Signature of Sponsor

AMEND Senate Bill No. 559* House Bill No. 697

by deleting Section 1 in its entirety and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 68-1-109, is amended by deleting the section in its entirety and by substituting instead the following:

Each hospital shall apply and use the following definitions when reporting on the joint annual reports to the department of health, center for health statistics. The center for health statistics and the comptroller of the treasury shall use and apply the following definitions when auditing or compiling statistics based on the reports or for any related reports or statistics:

(1) "Bad debts" are amounts considered to be uncollectible from accounts and notes receivable which are created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services and are collectible in money in the relatively near future.

(A) To constitute a "bad debt", the debt must meet the following criteria:

(i) The provider must be able to establish that reasonable collection efforts were made;

(ii) The debt was actually uncollectible when claimed as worthless; and

(iii) Sound business judgment established that there was no likelihood of recovery at any time in the future.

Accounts turned over to a collection agency should be classified as bad debt.

(B) If, after reasonable and customary attempts to collect a bill, the debt remains unpaid more than one hundred twenty (120) days from the date the first bill is mailed to the patient, then the debt may be deemed uncollectible.

Bankrupt accounts shall be considered bad debts, unless there is documented evidence that the medical bill caused bankruptcy. Such accounts would then be counted as charity.

(2) "Charity care" is reductions in charges made by the provider of services because of the indigence or medical indigence of the patient. The provider should apply the following guidelines for making a determination of indigence or medical indigence:

(A) The patient's indigence must be determined by the provider, not by the patient, (i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence);

(B) The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash and unnecessary for the patient's daily living), liabilities, and income and expenses. Indigence income means an amount not be exceed one hundred percent (100%) of the federal poverty guidelines. Medical indigence is a status reached when a person uses or commits all available current and expected resources to pay for medical bills and is not limited to a defined percent of the federal poverty guidelines. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence;

(C) The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill, (e.g., title XIX, local welfare agency and guardian); and

(D) The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

(E) Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the bad debt collection criteria.